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Medicare + Choice

Railroad retirement beneficiaries, like social security beneficiaries, are being offered additional health care options under the new Medicare + Choice Program provided by the Balanced Budget Act of 1997.

In addition to the traditional pay-per-visit (also known as fee-for-service) arrangement with any private doctor, or enrollment in a Medicare Managed Care Plan, e.g., health maintenance organizations (HMOs), eligible Medicare beneficiaries now have additional options. Beginning in November 1998, beneficiaries can enroll in other types of plans which will become effective in January 1999. These choices are designed to offer Medicare beneficiaries a variety of options similar to those available to the non-Medicare population. All of the new health plan options may not be available in all areas.

Individuals currently in Medicare Fee-for-Service, now called the Original Medicare Plan, or a Medicare Managed Care Plan which meets the new requirements, do not have to take any action unless they are dissatisfied with their current coverage and wish to make a change.

1. What are the health care choices available under Medicare + Choice?

- **Original Medicare Plan.—**The traditional pay-per-visit (also called fee-for-service) arrangement available nationwide.

(More)

- **Original Medicare Plan with Supplemental Policy.—**The Original Medicare Plan plus one of up to 10 standardized Medicare supplemental insurance policies (also called Medigap insurance) available through private companies.

- **Medicare Managed Care Plan.—**A Medicare approved network of doctors, hospitals, and other health care providers which agrees to give care in return for a set monthly payment from Medicare. A managed care plan may be any of the following: a Health Maintenance Organization (HMO), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), or a Health Maintenance Organization with a Point of Service Option (POS).

- **Private Fee-for-Service Plan (PFFS).—**A Medicare-approved private insurance plan. Medicare pays the plan a premium for Medicare-covered services. A PFFS Plan provides all Medicare benefits. Note: This is **not** the same as Medigap.

- **Medicare Medical Savings Account (MSA) Plan.—**A health insurance policy with a high yearly deductible. This is a test program for up to 390,000 Medicare beneficiaries. Medicare pays the premium for the Medicare MSA Plan and deposits money into a separate Medicare MSA beneficiaries establish. Beneficiaries use the money in the Medicare MSA to pay for medical expenses.

2. When and how will more information be made available to Medicare beneficiaries regarding the additional choices?

The Health Care Financing Administration (HCFA) is conducting several activities to notify the public about Medicare health plan choices.

In November, HCFA will mail a special version of the Medicare Handbook (called *Medicare & You*) containing information about Medicare health plan choices available locally to beneficiaries in five test States and will begin to phase in a national toll-free line to answer inquiries from those five States. The five States are Arizona, Florida, Ohio, Oregon and

Washington. The toll-free line is being phased in between October 1998 and August 1999. The first phase will be in the five test States, followed by five additional States in February and five more in May with the remainder in August. HCFA will use the five States to test the effectiveness of its National Medicare Education Program.

Also in November, HCFA will mail to all Medicare beneficiaries in all other States and territories an informational bulletin which includes information on the new Medicare health plan choices, and how to request comparative information on the health plan choices, plus a state-by-state listing of the telephone numbers to call for assistance.

HCFA has also established a Medicare Web site (www.medicare.gov) to provide a wide array of consumer-oriented information. This site includes *Medicare Compare*, a database providing information on available health plans and costs.

3. What should beneficiaries keep in mind regarding enrollment?

Beneficiaries don't need to do anything if they want to keep the Original Medicare Plan or their current Medicare Managed Care Plan. If they have a Medicare Managed Care Plan and wish to return to the original plan, they must disenroll in order to return to the Original Medicare Plan. If they want to enroll in a new Medicare health plan, they must contact the plan of their choice directly.

4. When can beneficiaries enroll in Medicare + Choice?

Not everyone who gets Medicare is eligible for Medicare + Choice. To be eligible for Medicare + Choice, a beneficiary must be enrolled in Medicare Parts A and B, must not have end-stage renal disease (end-stage renal disease is permanent kidney failure with dialysis or a transplant) and must live in the service area of the plan.

If eligible, beneficiaries may enroll in a Medicare + Choice plan beginning November 1, 1998. Every year, the month of November is the Annual Coordinated Election Period, during which time beneficiaries may enroll in any plan they wish.

There is also a Continuous Open Enrollment and Disenrollment Period which runs from November 1, 1998, through December 31, 2001. During this period, beneficiaries may change their election and enroll in a different plan at any time and as many times as they wish. However, the plan must be open and must have room for new members before they may enroll in it. Therefore, before leaving one plan, beneficiaries should make sure the new plan is open and is accepting new members. In addition, they may only enroll in a new Medicare Medical Savings Account Plan during the November Annual Coordinated Election Period.

5. Can the Railroad Retirement Board's staff advise beneficiaries on these choices and which may be best for them?

Information on the choices available will be made available by HCFA. While Board staff can provide general information and appropriate referrals, they cannot counsel beneficiaries as to what choice may be right for them. That is a personal decision each beneficiary must make based on his or her own situation.

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